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14.0 Introduction to Therapy and Treatment

class="introduction"

Many forms
of therapy
have been
developed
to treat a
wide array
of problems.

These
marines
who served
in Iraq and
Afghanistan
, together
with
community
mental
health
volunteers,
are part of
the Ocean
Therapy
program at
Camp
Pendleton, a
program in
which
learning to
surf is
combined
with group
discussions.

The
program
helps vets

recover,
especially
vets who
suffer from
post-
traumatic
stress
disorder
(PTSD).



In this chapter, you will see that approaches to therapy include both psychological and biological interventions, all with the goal of alleviating distress. Because psychological problems can originate from various sources—biology, genetics, childhood experiences, conditioning, and sociocultural influences—psychologists have developed many different therapeutic techniques and approaches. For example, some psychologists believe that psychotherapy should involve a close personal relationship between therapist and client, while others believe their main responsibility is to help the patient change behavior. The Ocean Therapy program shown

in [\[link\]](#) uses multiple approaches to support the mental health of veterans in the group.

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14.1 Mental Health Treatment: Past and Present

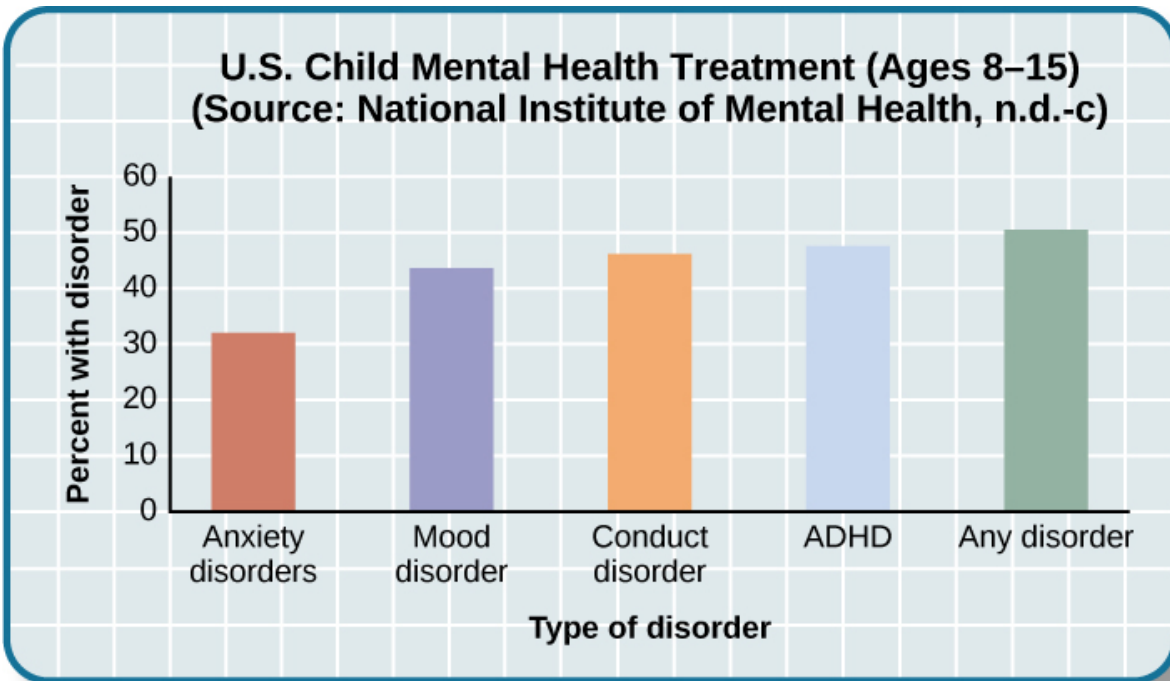
By the end of this section, you will be able to:

- Explain how people with psychological disorders have been treated throughout the ages
- Discuss deinstitutionalization
- Discuss the ways in which mental health services are delivered today
- Distinguish between voluntary and involuntary treatment

Before we explore the various approaches to therapy used today, let's begin our study of therapy by looking at how many people experience mental illness and how many receive treatment. According to the U.S. Department of Health and Human Services (2013), 19% of U.S. adults experienced mental illness in 2012. For teens (ages 13–18), the rate is similar to that of adults, and for children ages 8–15, current estimates suggest that 13% experience mental illness in a given year (National Institute of Mental Health [NIMH], n.d.-a)

With many different treatment options available, approximately how many people receive mental health treatment per year? According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2008, 13.4% of adults received treatment for a mental health issue (NIMH, n.d.-b).

Children and adolescents also receive mental health services. The Centers for Disease Control and Prevention's National Health and Nutrition Examination Survey (NHANES) found that approximately half (50.6%) of children with mental disorders had received treatment for their disorder within the past year (NIMH, n.d.-c). However, there were some differences between treatment rates by category of disorder ([link](#)). For example, children with anxiety disorders were least likely to have received treatment in the past year, while children with ADHD or a conduct disorder were more likely to receive treatment. Can you think of some possible reasons for these differences in receiving treatment?



About one-third to one-half of U.S. adolescents (ages 8–15) with mental disorders receive treatment, with behavior-related disorders more likely to be treated.

Considering the many forms of treatment for mental health disorders available today, how did these forms of treatment emerge? Let's take a look at the history of mental health treatment from the past (with some questionable approaches in light of modern understanding of mental illness) to where we are today.

TREATMENT IN THE PAST

For much of history, the mentally ill have been treated very poorly. It was believed that mental illness was caused by demonic possession, witchcraft, or an angry god (Szasz, 1960). For example, in medieval times, abnormal behaviors were viewed as a sign that a person was possessed by demons. If someone was considered to be possessed, there were several forms of treatment to release spirits from the individual. The most common treatment

was exorcism, often conducted by priests or other religious figures: Incantations and prayers were said over the person's body, and she may have been given some medicinal drinks. Another form of treatment for extreme cases of mental illness was trephining: A small hole was made in the afflicted individual's skull to release spirits from the body. Most people treated in this manner died. In addition to exorcism and trephining, other practices involved execution or imprisonment of people with psychological disorders. Still others were left to be homeless beggars. Generally speaking, most people who exhibited strange behaviors were greatly misunderstood and treated cruelly. The prevailing theory of psychopathology in earlier history was the idea that mental illness was the result of demonic possession by either an evil spirit or an evil god because early beliefs incorrectly attributed all unexplainable phenomena to deities deemed either good or evil.

From the late 1400s to the late 1600s, a common belief perpetuated by some religious organizations was that some people made pacts with the devil and committed horrible acts, such as eating babies (Blumberg, 2007). These people were considered to be witches and were tried and condemned by courts—they were often burned at the stake. Worldwide, it is estimated that tens of thousands of mentally ill people were killed after being accused of being witches or under the influence of witchcraft (Hemphill, 1966)

By the 18th century, people who were considered odd and unusual were placed in asylums ([\[link\]](#)). **Asylums** were the first institutions created for the specific purpose of housing people with psychological disorders, but the focus was ostracizing them from society rather than treating their disorders. Often these people were kept in windowless dungeons, beaten, chained to their beds, and had little to no contact with caregivers.



This painting by Francisco Goya, called *The Madhouse*, depicts a mental asylum and its inhabitants in the early 1800s. It portrays those with psychological disorders as victims.

In the late 1700s, a French physician, Philippe Pinel, argued for more humane treatment of the mentally ill. He suggested that they be unchained and talked to, and that's just what he did for patients at La Salpêtrière in Paris in 1795 ([link](#)). Patients benefited from this more humane treatment, and many were able to leave the hospital.



This painting by Tony Robert-Fleury depicts Dr. Philippe Pinel ordering the removal of chains from patients at the Salpêtrière asylum in Paris.

In the 19th century, Dorothea Dix led reform efforts for mental health care in the United States. She investigated how those who are mentally ill and poor were cared for, and she discovered an underfunded and unregulated system that perpetuated abuse of this population (Tiffany, 1891). Horrified by her findings, Dix began lobbying various state legislatures and the U.S. Congress for change (Tiffany, 1891). Her efforts led to the creation of the first mental asylums in the United States.

Despite reformers' efforts, however, a typical asylum was filthy, offered very little treatment, and often kept people for decades. At Willard Psychiatric Center in upstate New York, for example, one treatment was to submerge patients in cold baths for long periods of time. Electroshock treatment was also used, and the way the treatment was administered often broke patients' backs; in 1943, doctors at Willard administered 1,443 shock treatments (Willard Psychiatric Center, 2009). (Electroshock is now called

electroconvulsive treatment, and the therapy is still used, but with safeguards and under anesthesia. A brief application of electric stimulus is used to produce a generalized seizure. Controversy continues over its effectiveness versus the side effects.) Many of the wards and rooms were so cold that a glass of water would be frozen by morning (Willard Psychiatric Center, 2009). Willard's doors were not closed until 1995. Conditions like these remained commonplace until well into the 20th century.

Starting in 1954 and gaining popularity in the 1960s, antipsychotic medications were introduced. These proved a tremendous help in controlling the symptoms of certain psychological disorders, such as psychosis. Psychosis was a common diagnosis of individuals in mental hospitals, and it was often evidenced by symptoms like hallucinations and delusions, indicating a loss of contact with reality. Then in 1963, Congress passed and John F. Kennedy signed the Mental Retardation Facilities and Community Mental Health Centers Construction Act, which provided federal support and funding for community mental health centers (National Institutes of Health, 2013). This legislation changed how mental health services were delivered in the United States. It started the process of **deinstitutionalization**, the closing of large asylums, by providing for people to stay in their communities and be treated locally. In 1955, there were 558,239 severely mentally ill patients institutionalized at public hospitals (Torrey, 1997). By 1994, by percentage of the population, there were 92% fewer hospitalized individuals (Torrey, 1997).

MENTAL HEALTH TREATMENT TODAY

Today, there are community mental health centers across the nation. They are located in neighborhoods near the homes of clients, and they provide large numbers of people with mental health services of various kinds and for many kinds of problems. Unfortunately, part of what occurred with deinstitutionalization was that those released from institutions were supposed to go to newly created centers, but the system was not set up effectively. Centers were underfunded, staff was not trained to handle severe illnesses such as schizophrenia, there was high staff burnout, and no provision was made for the other services people needed, such as housing, food, and job training. Without these supports, those people released under

deinstitutionalization often ended up homeless. Even today, a large portion of the homeless population is considered to be mentally ill. Statistics show that 26% of homeless adults living in shelters experience mental illness (U.S. Department of Housing and Urban Development [HUD], 2011).

Another group of the mentally ill population is involved in the corrections system. According to a 2006 special report by the Bureau of Justice Statistics (BJS), approximately 705,600 mentally ill adults were incarcerated in the state prison system, and another 78,800 were incarcerated in the federal prison system. A further 479,000 were in local jails. According to the study, “people with mental illnesses are overrepresented in probation and parole populations at estimated rates ranging from two to four times the general population” (Prins & Draper, 2009, p. 23). The Treatment Advocacy Center reported that the growing number of mentally ill inmates has placed a burden on the correctional system (Torrey et al., 2014).

Today, instead of asylums, there are psychiatric hospitals run by state governments and local community hospitals focused on short-term care. In all types of hospitals, the emphasis is on short-term stays, with the average length of stay being less than two weeks and often only several days. This is partly due to the very high cost of psychiatric hospitalization, which can be about \$800 to \$1000 per night (Stensland, Watson, & Grazier, 2012). Therefore, insurance coverage often limits the length of time a person can be hospitalized for treatment. Usually individuals are hospitalized only if they are an imminent threat to themselves or others.

Most people suffering from mental illnesses are not hospitalized. If someone is feeling very depressed, complains of hearing voices, or feels anxious all the time, he or she might seek psychological treatment. A friend, spouse, or parent might refer someone for treatment. The individual might go see his primary care physician first and then be referred to a mental health practitioner.

Some people seek treatment because they are involved with the state’s child protective services—that is, their children have been removed from their care due to abuse or neglect. The parents might be referred to psychiatric or substance abuse facilities and the children would likely receive treatment

for trauma. If the parents are interested in and capable of becoming better parents, the goal of treatment might be family reunification. For other children whose parents are unable to change—for example, the parent or parents who are heavily addicted to drugs and refuse to enter treatment—the goal of therapy might be to help the children adjust to foster care and/or adoption.

Some people seek therapy because the criminal justice system referred them or required them to go. For some individuals, for example, attending weekly counseling sessions might be a condition of parole. If an individual is mandated to attend therapy, she is seeking services involuntarily.

Involuntary treatment refers to therapy that is not the individual's choice. Other individuals might voluntarily seek treatment. **Voluntary treatment** means the person chooses to attend therapy to obtain relief from symptoms.

Psychological treatment can occur in a variety of places. An individual might go to a community mental health center or a practitioner in private or community practice. A child might see a school counselor, school psychologist, or school social worker. An incarcerated person might receive group therapy in prison. There are many different types of treatment providers, and licensing requirements vary from state to state. Besides psychologists and psychiatrists, there are clinical social workers, marriage and family therapists, and trained religious personnel who also perform counseling and therapy.

A range of funding sources pay for mental health treatment: health insurance, government, and private pay. In the past, even when people had health insurance, the coverage would not always pay for mental health services. This changed with the Mental Health Parity and Addiction Equity Act of 2008, which requires group health plans and insurers to make sure there is parity of mental health services (U.S. Department of Labor, n.d.). This means that co-pays, total number of visits, and deductibles for mental health and substance abuse treatment need to be equal to and cannot be more restrictive or harsher than those for physical illnesses and medical/surgical problems.

Finding treatment sources is also not always easy: there may be limited options, especially in rural areas and low-income urban areas; waiting lists;

poor quality of care available for indigent patients; and financial obstacles such as co-pays, deductibles, and time off from work. Over 85% of the 1,669 federally designated mental health professional shortage areas are rural; often primary care physicians and law enforcement are the first-line mental health providers (Ivey, Scheffler, & Zazzali, 1998), although they do not have the specialized training of a mental health professional, who often would be better equipped to provide care. Availability, accessibility, and acceptability (the stigma attached to mental illness) are all problems in rural areas. Approximately two-thirds of those with symptoms receive no care at all (U.S. Department of Health and Human Services, 2005; Wagenfeld, Murray, Mohatt, & DeBruynb, 1994). At the end of 2013, the U.S. Department of Agriculture announced an investment of \$50 million to help improve access and treatment for mental health problems as part of the Obama administration's effort to strengthen rural communities.

Summary

It was once believed that people with psychological disorders, or those exhibiting strange behavior, were possessed by demons. These people were forced to take part in exorcisms, were imprisoned, or executed. Later, asylums were built to house the mentally ill, but the patients received little to no treatment, and many of the methods used were cruel. Philippe Pinel and Dorothea Dix argued for more humane treatment of people with psychological disorders. In the mid-1960s, the deinstitutionalization movement gained support and asylums were closed, enabling people with mental illness to return home and receive treatment in their own communities. Some did go to their family homes, but many became homeless due to a lack of resources and support mechanisms.

Today, instead of asylums, there are psychiatric hospitals run by state governments and local community hospitals, with the emphasis on short-term stays. However, most people suffering from mental illness are not hospitalized. A person suffering symptoms could speak with a primary care physician, who most likely would refer him to someone who specializes in therapy. The person can receive outpatient mental health services from a variety of sources, including psychologists, psychiatrists, marriage and family therapists, school counselors, clinical social workers, and religious

personnel. These therapy sessions would be covered through insurance, government funds, or private (self) pay.

Review Questions

Exercise:

Problem:

Who of the following does not support the humane and improved treatment of mentally ill persons?

- A. Philippe Pinel
- B. medieval priests
- C. Dorothea Dix
- D. All of the above

Solution:

B

Exercise:

Problem:

The process of closing large asylums and providing for people to stay in the community to be treated locally is known as _____.

- A. deinstitutionalization
- B. exorcism
- C. deactivation
- D. decentralization

Solution:

A

Exercise:

Problem:

Joey was convicted of domestic violence. As part of his sentence, the judge has ordered that he attend therapy for anger management. This is considered _____ treatment.

- A. involuntary
- B. voluntary
- C. forced
- D. mandatory

Solution:

A

Exercise:**Problem:**

Today, most people with psychological problems are not hospitalized. Typically they are only hospitalized if they _____.

- A. have schizophrenia
- B. have insurance
- C. are an imminent threat to themselves or others
- D. require therapy

Solution:

C

Critical Thinking Questions**Exercise:**

Problem:

People with psychological disorders have been treated poorly throughout history. Describe some efforts to improve treatment, include explanations for the success or lack thereof.

Solution:

Beginning in the Middle Ages and up until the mid-20th century, the mentally ill were misunderstood and treated cruelly. In the 1700s, Philippe Pinel advocated for patients to be unchained, and he was able to affect this in a Paris hospital. In the 1800s, Dorothea Dix urged the government to provide better funded and regulated care, which led to the creation of asylums, but treatment generally remained quite poor. Federally mandated deinstitutionalization in the 1960s began the elimination of asylums, but it was often inadequate in providing the infrastructure for replacement treatment.

Exercise:**Problem:**

Usually someone is hospitalized only if they are an imminent threat to themselves or others. Describe a situation that might meet these criteria.

Solution:

Frank is severely depressed. He lost his job one year ago and has not been able to find another one. A few months after losing his job, his home was foreclosed and his wife left him. Lately, he has been thinking that he would be better off dead. He's begun giving his possessions away and has purchased a handgun. He plans to kill himself on what would have been his 20th wedding anniversary, which is coming up in a few weeks.

Glossary

asylum

institution created for the specific purpose of housing people with psychological disorders

deinstitutionalization

process of closing large asylums and integrating people back into the community where they can be treated locally

involuntary treatment

therapy that is mandated by the courts or other systems

voluntary treatment

therapy that a person chooses to attend in order to obtain relief from her symptoms

14.2 Types of Treatment

By the end of this section, you will be able to:

- Distinguish between psychotherapy and biomedical therapy
- Recognize various orientations to psychotherapy
- Discuss psychotropic medications and recognize which medications are used to treat specific psychological disorders

Two types of therapy are psychotherapy and biomedical therapy (also called somatic therapy). Both types of treatment help people with psychological disorders, such as depression, anxiety, and schizophrenia. **Psychotherapy** is a psychological treatment that employs various methods to help someone overcome personal problems, or to attain personal growth. In modern practice, it has evolved into what is known as psychodynamic therapy, which will be discussed later. **Biomedical therapy** involves medication and/or medical procedures to treat psychological disorders. First, we will explore the various psychotherapeutic orientations outlined in [\[link\]](#) (many of these orientations were discussed in the Introduction chapter).

Type	Description	Example
Psychodynamic psychotherapy	Talk therapy based on belief that the unconscious and childhood conflicts impact behavior	Patient talks about his past
Play therapy	Psychoanalytical therapy wherein interaction with toys is used instead of talk; used in child therapy	Patient (child) acts out family scenes with dolls

Type	Description	Example
Behavior therapy	Principles of learning applied to change undesirable behaviors	Patient learns to overcome fear of elevators through several stages of relaxation techniques
Cognitive therapy	Awareness of cognitive process helps patients eliminate thought patterns that lead to distress	Patient learns not to overgeneralize failure based on single failure
Cognitive-behavioral therapy	Work to change cognitive distortions and self-defeating behaviors	Patient learns to identify self-defeating behaviors to overcome an eating disorder
Humanistic therapy	Increase self-awareness and acceptance through focus on conscious thoughts	Patient learns to articulate thoughts that keep her from achieving her goals

Various Psychotherapy Techniques

PSYCHOTHERAPY TECHNIQUES: PSYCHOANALYSIS

Psychoanalysis was developed by Sigmund Freud and was the first form of psychotherapy. It was the dominant therapeutic technique in the early 20th century, but it has since waned significantly in popularity. Freud believed most of our psychological problems are the result of repressed impulses and

trauma experienced in childhood, and he believed psychoanalysis would help uncover long-buried feelings. In a psychoanalyst's office, you might see a patient lying on a couch speaking of dreams or childhood memories, and the therapist using various Freudian methods such as free association and dream analysis ([link](#)). In **free association**, the patient relaxes and then says whatever comes to mind at the moment. However, Freud felt that the ego would at times try to block, or repress, unacceptable urges or painful conflicts during free association. Consequently, a patient would demonstrate resistance to recalling these thoughts or situations. In **dream analysis**, a therapist interprets the underlying meaning of dreams.

Psychoanalysis is a therapy approach that typically takes years. Over the course of time, the patient reveals a great deal about himself to the therapist. Freud suggested that during this patient-therapist relationship, the patient comes to develop strong feelings for the therapist—maybe positive feelings, maybe negative feelings. Freud called this **transference**: the patient transfers all the positive or negative emotions associated with the patient's other relationships to the psychoanalyst. For example, Crystal is seeing a psychoanalyst. During the years of therapy, she comes to see her therapist as a father figure. She transfers her feelings about her father onto her therapist, perhaps in an effort to gain the love and attention she did not receive from her own father.



This is the famous couch in

Freud's consulting room. Patients were instructed to lie comfortably on the couch and to face away from Freud in order to feel less inhibited and to help them focus. Today, a psychotherapy patient is not likely to lie on a couch; instead he is more likely to sit facing the therapist (Prochaska & Norcross, 2010). (credit: Robert Huffstutter)

Today, Freud's psychoanalytical perspective has been expanded upon by the developments of subsequent theories and methodologies: the psychodynamic perspective. This approach to therapy remains centered on the role of people's internal drives and forces, but treatment is less intensive than Freud's original model.

PSYCHOTHERAPY: PLAY THERAPY

Play therapy is often used with children since they are not likely to sit on a couch and recall their dreams or engage in traditional talk therapy. This technique uses a therapeutic process of play to "help clients prevent or resolve psychosocial difficulties and achieve optimal growth" (O'Connor, 2000, p. 7). The idea is that children play out their hopes, fantasies, and traumas while using dolls, stuffed animals, and sandbox figurines ([link](#)). Play therapy can also be used to help a therapist make a diagnosis. The therapist observes how the child interacts with toys (e.g., dolls, animals, and home settings) in an effort to understand the roots of the child's disturbed behavior. Play therapy can be nondirective or directive. In nondirective play therapy, children are encouraged to work through their problems by playing freely while the therapist observes (LeBlanc & Ritchie, 2001). In directive play therapy, the therapist provides more structure and guidance in the play session by suggesting topics, asking questions, and even playing with the child (Harter, 1977).

PSYCHOTHERAPY: BEHAVIOR THERAPY

In **psychoanalysis**, therapists help their patients look into their past to uncover repressed feelings. In **behavior therapy**, a therapist employs principles of learning to help clients change undesirable behaviors—rather than digging deeply into one's unconscious. Therapists with this orientation believe that dysfunctional behaviors, like phobias and bedwetting, can be changed by teaching clients new, more constructive behaviors. Behavior therapy employs both classical and operant conditioning techniques to change behavior.

One type of behavior therapy utilizes classical conditioning techniques. Therapists using these techniques believe that dysfunctional behaviors are conditioned responses. Applying the conditioning principles developed by Ivan Pavlov, these therapists seek to recondition their clients and thus change their behavior. Emmie is eight years old, and frequently wets her bed at night. She's been invited to several sleepovers, but she won't go because of her problem. Using a type of conditioning therapy, Emmie begins to sleep on a liquid-sensitive bed pad that is hooked to an alarm. When moisture touches the pad, it sets off the alarm, waking up Emmie. When this process is repeated enough times, Emmie develops an association between urinary relaxation and waking up, and this stops the bedwetting. Emmie has now gone three weeks without wetting her bed and is looking forward to her first sleepover this weekend.

One commonly used classical conditioning therapeutic technique is **counterconditioning**: a client learns a new response to a stimulus that has previously elicited an undesirable behavior. Two counterconditioning techniques are aversive conditioning and exposure therapy. **Aversive conditioning** uses an unpleasant stimulus to stop an undesirable behavior. Therapists apply this technique to eliminate addictive behaviors, such as smoking, nail biting, and drinking. In aversion therapy, clients will typically engage in a specific behavior (such as nail biting) and at the same time are exposed to something unpleasant, such as a mild electric shock or a bad taste. After repeated associations between the unpleasant stimulus and the behavior, the client can learn to stop the unwanted behavior.

Aversion therapy has been used effectively for years in the treatment of alcoholism (Davidson, 1974; Elkins, 1991; Streeton & Whelan, 2001). One common way this occurs is through a chemically based substance known as Antabuse. When a person takes Antabuse and then consumes alcohol, uncomfortable side effects result including nausea, vomiting, increased heart rate, heart palpitations, severe headache, and shortness of breath. Antabuse is repeatedly paired with alcohol until the client associates alcohol with unpleasant feelings, which decreases the client's desire to consume alcohol. Antabuse creates a conditioned aversion to alcohol because it replaces the original pleasure response with an unpleasant one.

In **exposure therapy**, a therapist seeks to treat clients' fears or anxiety by presenting them with the object or situation that causes their problem, with the idea that they will eventually get used to it. This can be done via reality, imagination, or virtual reality. Exposure therapy was first reported in 1924 by Mary Cover Jones, who is considered the mother of behavior therapy. Jones worked with a boy named Peter who was afraid of rabbits. Her goal was to replace Peter's fear of rabbits with a conditioned response of relaxation, which is a response that is incompatible with fear. How did she do it? Jones began by placing a caged rabbit on the other side of a room with Peter while he ate his afternoon snack. Over the course of several days, Jones moved the rabbit closer and closer to where Peter was seated with his snack. After two months of being exposed to the rabbit while relaxing with his snack, Peter was able to hold the rabbit and pet it while eating (Jones, 1924).

Thirty years later, Joseph Wolpe (1958) refined Jones's techniques, giving us the behavior therapy technique of exposure therapy that is used today. A popular form of exposure therapy is **systematic desensitization**, wherein a calm and pleasant state is gradually associated with increasing levels of anxiety-inducing stimuli. The idea is that you can't be nervous and relaxed at the same time. Therefore, if you can learn to relax when you are facing environmental stimuli that make you nervous or fearful, you can eventually eliminate your unwanted fear response (Wolpe, 1958).

How does exposure therapy work? Jayden is terrified of elevators. Nothing bad has ever happened to him on an elevator, but he's so afraid of elevators

that he will always take the stairs. That wasn't a problem when Jayden worked on the second floor of an office building, but now he has a new job—on the 29th floor of a skyscraper in downtown Los Angeles. Jayden knows he can't climb 29 flights of stairs in order to get to work each day, so he decided to see a behavior therapist for help. The therapist asks Jayden to first construct a hierarchy of elevator-related situations that elicit fear and anxiety. They range from situations of mild anxiety such as being nervous around the other people in the elevator, to the fear of getting an arm caught in the door, to panic-provoking situations such as getting trapped or the cable snapping. Next, the therapist uses progressive relaxation. She teaches Jayden how to relax each of his muscle groups so that he achieves a drowsy, relaxed, and comfortable state of mind. Once he's in this state, she asks Jayden to imagine a mildly anxiety-provoking situation. Jayden is standing in front of the elevator thinking about pressing the call button.

If this scenario causes Jayden anxiety, he lifts his finger. The therapist would then tell Jayden to forget the scene and return to his relaxed state. She repeats this scenario over and over until Jayden can imagine himself pressing the call button without anxiety. Over time the therapist and Jayden use progressive relaxation and imagination to proceed through all of the situations on Jayden's hierarchy until he becomes desensitized to each one. After this, Jayden and the therapist begin to practice what he only previously envisioned in therapy, gradually going from pressing the button to actually riding an elevator. The goal is that Jayden will soon be able to take the elevator all the way up to the 29th floor of his office without feeling any anxiety.

Sometimes, it's too impractical, expensive, or embarrassing to re-create anxiety-producing situations, so a therapist might employ **virtual reality exposure therapy** by using a simulation to help conquer fears. Virtual reality exposure therapy has been used effectively to treat numerous anxiety disorders such as the fear of public speaking, claustrophobia (fear of enclosed spaces), aviophobia (fear of flying), and post-traumatic stress disorder (PTSD), a trauma and stressor-related disorder (Gerardi, Cukor, Difede, Rizzo, & Rothbaum, 2010).

Some behavior therapies employ operant conditioning. Recall what you learned about operant conditioning: We have a tendency to repeat behaviors that are reinforced. What happens to behaviors that are not reinforced? They become extinguished. These principles can be applied to help people with a wide range of psychological problems. For instance, operant conditioning techniques designed to reinforce positive behaviors and punish unwanted behaviors have been an effective tool to help children with autism (Lovaas, 1987, 2003; Sallows & Graupner, 2005; Wolf & Risley, 1967). This technique is called Applied Behavior Analysis (ABA). In this treatment, child-specific reinforcers (e.g., stickers, praise, candy, bubbles, and extra play time) are used to reward and motivate autistic children when they demonstrate desired behaviors such as sitting on a chair when requested, verbalizing a greeting, or making eye contact. Punishment such as a timeout or a sharp “No!” from the therapist or parent might be used to discourage undesirable behaviors such as pinching, scratching, and pulling hair.

One popular operant conditioning intervention is called the **token economy**. This involves a controlled setting where individuals are reinforced for desirable behaviors with tokens, such as a poker chip, that can be exchanged for items or privileges. Token economies are often used in psychiatric hospitals to increase patient cooperation and activity levels. Patients are rewarded with tokens when they engage in positive behaviors (e.g., making their beds, brushing their teeth, coming to the cafeteria on time, and socializing with other patients). They can later exchange the tokens for extra TV time, private rooms, visits to the canteen, and so on (Dickerson, Tenhula, & Green-Paden, 2005).

PSYCHOTHERAPY: COGNITIVE THERAPY

Cognitive therapy is a form of psychotherapy that focuses on how a person’s thoughts lead to feelings of distress. The idea behind cognitive therapy is that how you think determines how you feel and act. Cognitive therapists help their clients change dysfunctional thoughts in order to relieve distress. They help a client see how they misinterpret a situation (cognitive distortion). For example, a client may overgeneralize. Because Ray failed one test in his Psychology 101 course, he feels he is stupid and

worthless. These thoughts then cause his mood to worsen. Therapists also help clients recognize when they blow things out of proportion. Because Ray failed his Psychology 101 test, he has concluded that he's going to fail the entire course and probably flunk out of college altogether. These errors in thinking have contributed to Ray's feelings of distress. His therapist will help him challenge these irrational beliefs, focus on their illogical basis, and correct them with more logical and rational thoughts and beliefs.

Cognitive therapy was developed by psychiatrist Aaron Beck in the 1960s. His initial focus was on depression and how a client's self-defeating attitude served to maintain a depression despite positive factors in her life (Beck, Rush, Shaw, & Emery, 1979). Through questioning, a cognitive therapist can help a client recognize dysfunctional ideas, challenge catastrophizing thoughts about themselves and their situations, and find a more positive way to view things (Beck, 2011).

PSYCHOTHERAPY: COGNITIVE-BEHAVIORAL THERAPY

Cognitive-behavioral therapists focus much more on present issues than on a patient's childhood or past, as in other forms of psychotherapy. One of the first forms of cognitive-behavioral therapy was **rational emotive therapy (RET)**, which was founded by Albert Ellis and grew out of his dislike of Freudian psychoanalysis (Daniel, n.d.). Behaviorists such as Joseph Wolpe also influenced Ellis's therapeutic approach (National Association of Cognitive-Behavioral Therapists, 2009).

Cognitive-behavioral therapy (CBT) helps clients examine how their thoughts affect their behavior. It aims to change cognitive distortions and self-defeating behaviors. In essence, this approach is designed to change the way people think as well as how they act. It is similar to cognitive therapy in that CBT attempts to make individuals aware of their irrational and negative thoughts and helps people replace them with new, more positive ways of thinking. It is also similar to behavior therapies in that CBT teaches people how to practice and engage in more positive and healthy approaches to daily situations. In total, hundreds of studies have shown the effectiveness of cognitive-behavioral therapy in the treatment of numerous

psychological disorders such as depression, PTSD, anxiety disorders, eating disorders, bipolar disorder, and substance abuse (Beck Institute for Cognitive Behavior Therapy, n.d.). For example, CBT has been found to be effective in decreasing levels of hopelessness and suicidal thoughts in previously suicidal teenagers (Alavi, Sharifi, Ghanizadeh, & Dehbozorgi, 2013). Cognitive-behavioral therapy has also been effective in reducing PTSD in specific populations, such as transit workers (Lowinger & Rombom, 2012).

Cognitive-behavioral therapy aims to change cognitive distortions and self-defeating behaviors using techniques like the ABC model. With this model, there is an **A**ction (sometimes called an activating event), the **B**elief about the event, and the **C**onsequences of this belief. Let's say, Jon and Joe both go to a party. Jon and Joe each have met a young woman at the party: Jon is talking with Megan most of the party, and Joe is talking with Amanda. At the end of the party, Jon asks Megan for her phone number and Joe asks Amanda. Megan tells Jon she would rather not give him her number, and Amanda tells Joe the same thing. Both Jon and Joe are surprised, as they thought things were going well. What can Jon and Joe tell themselves about why the women were not interested? Let's say Jon tells himself he is a loser, or is ugly, or "has no game." Jon then gets depressed and decides not to go to another party, which starts a cycle that keeps him depressed. Joe tells himself that he had bad breath, goes out and buys a new toothbrush, goes to another party, and meets someone new.

Jon's belief about what happened results in a consequence of further depression, whereas Joe's belief does not. Jon is internalizing the attribution or reason for the rebuffs, which triggers his depression. On the other hand, Joe is externalizing the cause, so his thinking does not contribute to feelings of depression. Cognitive-behavioral therapy examines specific maladaptive and automatic thoughts and cognitive distortions. Some examples of cognitive distortions are all-or-nothing thinking, overgeneralization, and jumping to conclusions. In overgeneralization, someone takes a small situation and makes it huge—for example, instead of saying, "This particular woman was not interested in me," the man says, "I am ugly, a loser, and no one is ever going to be interested in me."

All or nothing thinking, which is a common type of cognitive distortion for people suffering from depression, reflects extremes. In other words, everything is black or white. After being turned down for a date, Jon begins to think, “No woman will ever go out with me. I’m going to be alone forever.” He begins to feel anxious and sad as he contemplates his future.

The third kind of distortion involves jumping to conclusions—assuming that people are thinking negatively about you or reacting negatively to you, even though there is no evidence. Consider the example of Savannah and Hillaire, who recently met at a party. They have a lot in common, and Savannah thinks they could become friends. She calls Hillaire to invite her for coffee. Since Hillaire doesn’t answer, Savannah leaves her a message. Several days go by and Savannah never hears back from her potential new friend. Maybe Hillaire never received the message because she lost her phone or she is too busy to return the phone call. But if Savannah believes that Hillaire didn’t like Savannah or didn’t want to be her friend, she is demonstrating the cognitive distortion of jumping to conclusions.

How effective is CBT? One client said this about his cognitive-behavioral therapy:

"I have had many painful episodes of depression in my life, and this has had a negative effect on my career and has put considerable strain on my friends and family. The treatments I have received, such as taking antidepressants and psychodynamic counseling, have helped [me] to cope with the symptoms and to get some insights into the roots of my problems. CBT has been by far the most useful approach I have found in tackling these mood problems. It has raised my awareness of how my thoughts impact on my moods. How the way I think about myself, about others and about the world can lead me into depression. It is a practical approach, which does not dwell so much on childhood experiences, whilst acknowledging that it was then that these patterns were learned. It looks at what is happening now, and gives tools to manage these moods on a daily basis. (Martin, 2007, n.p.)"

PSYCHOTHERAPY: HUMANISTIC THERAPY

Humanistic psychology focuses on helping people achieve their potential. So it makes sense that the goal of **humanistic therapy** is to help people become more self-aware and accepting of themselves. In contrast to psychoanalysis, humanistic therapists focus on conscious rather than unconscious thoughts. They also emphasize the patient's present and future, as opposed to exploring the patient's past.

Psychologist Carl Rogers developed a therapeutic orientation known as **Rogerian**, or **client-centered therapy**. Note the change from *patients* to *clients*. Rogers (1951) felt that the term patient suggested the person seeking help was sick and looking for a cure. Since this is a form of **nondirective therapy**, a therapeutic approach in which the therapist does not give advice or provide interpretations but helps the person to identify conflicts and understand feelings, Rogers (1951) emphasized the importance of the person taking control of his own life to overcome life's challenges.

In client-centered therapy, the therapist uses the technique of active listening. In active listening, the therapist acknowledges, restates, and clarifies what the client expresses. Therapists also practice what Rogers called **unconditional positive regard**, which involves not judging clients and simply accepting them for who they are. Rogers (1951) also felt that therapists should demonstrate genuineness, empathy, and acceptance toward their clients because this helps people become more accepting of themselves, which results in personal growth.

EVALUATING VARIOUS FORMS OF PSYCHOTHERAPY

How can we assess the effectiveness of psychotherapy? Is one technique more effective than another? For anyone considering therapy, these are important questions. According to the American Psychological Association, three factors work together to produce successful treatment. The first is the use of evidence-based treatment that is deemed appropriate for your particular issue. The second important factor is the clinical expertise of the psychologist or therapist. The third factor is your own characteristics, values, preferences, and culture. Many people begin psychotherapy feeling like their problem will never be resolved; however, psychotherapy helps

people see that they can do things to make their situation better. Psychotherapy can help reduce a person's anxiety, depression, and maladaptive behaviors. Through psychotherapy, individuals can learn to engage in healthy behaviors designed to help them better express emotions, improve relationships, think more positively, and perform more effectively at work or school.

Many studies have explored the effectiveness of psychotherapy. For example, one large-scale study that examined 16 meta-analyses of CBT reported that it was equally effective or more effective than other therapies in treating PTSD, generalized anxiety disorder, depression, and social phobia (Butler, Chapman, Forman, & Beck, 2006). Another study found that CBT was as effective at treating depression (43% success rate) as prescription medication (50% success rate) compared to the placebo rate of 25% (DeRubeis et al., 2005). Another meta-analysis found that psychodynamic therapy was also as effective at treating these types of psychological issues as CBT (Shedler, 2010). However, no studies have found one psychotherapeutic approach more effective than another (Abbass, Kisely, & Kroenke, 2006; Chorpita et al., 2011), nor have they shown any relationship between a client's treatment outcome and the level of the clinician's training or experience (Wampold, 2007). Regardless of which type of psychotherapy an individual chooses, one critical factor that determines the success of treatment is the person's relationship with the psychologist or therapist.

Summary

Psychoanalysis was developed by Sigmund Freud. Freud's theory is that a person's psychological problems are the result of repressed impulses or childhood trauma. The goal of the therapist is to help a person uncover buried feelings by using techniques such as free association and dream analysis.

Play therapy is a psychodynamic therapy technique often used with children. The idea is that children play out their hopes, fantasies, and traumas, using dolls, stuffed animals, and sandbox figurines.

In behavior therapy, a therapist employs principles of learning from classical and operant conditioning to help clients change undesirable behaviors. Counterconditioning is a commonly used therapeutic technique in which a client learns a new response to a stimulus that has previously elicited an undesirable behavior via classical conditioning. Principles of operant conditioning can be applied to help people deal with a wide range of psychological problems. Token economy is an example of a popular operant conditioning technique.

Cognitive therapy is a technique that focuses on how thoughts lead to feelings of distress. The idea behind cognitive therapy is that how you think determines how you feel and act. Cognitive therapists help clients change dysfunctional thoughts in order to relieve distress. Cognitive-behavioral therapy explores how our thoughts affect our behavior. Cognitive-behavioral therapy aims to change cognitive distortions and self-defeating behaviors.

Humanistic therapy focuses on helping people achieve their potential. One form of humanistic therapy developed by Carl Rogers is known as client-centered or Rogerian therapy. Client-centered therapists use the techniques of active listening, unconditional positive regard, genuineness, and empathy to help clients become more accepting of themselves.

Often in combination with psychotherapy, people can be prescribed biologically based treatments such as psychotropic medications and/or other medical procedures such as electro-convulsive therapy.

Review Questions

Exercise:

Problem:

The idea behind _____ is that how you think determines how you feel and act.

- A. cognitive therapy
- B. cognitive-behavioral therapy

- C. behavior therapy
 - D. client-centered therapy
-

Solution:

A

Exercise:

Problem:

Mood stabilizers, such as lithium, are used to treat _____.

- A. anxiety disorders
 - B. depression
 - C. bipolar disorder
 - D. ADHD
-

Solution:

C

Exercise:

Problem:

Clay is in a therapy session. The therapist asks him to relax and say whatever comes to his mind at the moment. This therapist is using _____, which is a technique of _____.

- A. active listening; client-centered therapy
 - B. systematic desensitization; behavior therapy
 - C. transference; psychoanalysis
 - D. free association; psychoanalysis
-

Solution:

D

Critical Thinking Question

Exercise:

Problem:

Imagine that you are a psychiatrist. Your patient, Pat, comes to you with the following symptoms: anxiety and feelings of sadness. Which therapeutic approach would you recommend and why?

Solution:

I would recommend psychodynamic talk therapy or cognitive therapy to help the person see how her thoughts and behaviors are having negative effects.

Glossary

aversive conditioning

counterconditioning technique that pairs an unpleasant stimulant with an undesirable behavior

behavior therapy

therapeutic orientation that employs principles of learning to help clients change undesirable behaviors

biomedical therapy

treatment that involves medication and/or medical procedures to treat psychological disorders

cognitive-behavioral therapy

form of psychotherapy that aims to change cognitive distortions and self-defeating behaviors

cognitive therapy

form of psychotherapy that focuses on how a person's thoughts lead to feelings of distress, with the aim of helping them change these irrational thoughts

counterconditioning

classical conditioning therapeutic technique in which a client learns a new response to a stimulus that has previously elicited an undesirable behavior

dream analysis

technique in psychoanalysis in which patients recall their dreams and the psychoanalyst interprets them to reveal unconscious desires or struggles

electroconvulsive therapy (ECT)

type of biomedical therapy that involves using an electrical current to induce seizures in a person to help alleviate the effects of severe depression

exposure therapy

counterconditioning technique in which a therapist seeks to treat a client's fear or anxiety by presenting the feared object or situation with the idea that the person will eventually get used to it

free association

technique in psychoanalysis in which the patient says whatever comes to mind at the moment

humanistic therapy

therapeutic orientation aimed at helping people become more self-aware and accepting of themselves

nondirective therapy

therapeutic approach in which the therapist does not give advice or provide interpretations but helps the person identify conflicts and understand feelings

play therapy

therapeutic process, often used with children, that employs toys to help them resolve psychological problems

psychoanalysis

therapeutic orientation developed by Sigmund Freud that employs free association, dream analysis, and transference to uncover repressed feelings

psychotherapy

(also, psychodynamic psychotherapy) psychological treatment that employs various methods to help someone overcome personal problems, or to attain personal growth

rational emotive therapy (RET)

form of cognitive-behavioral therapy

Rogesian (client-centered therapy)

non-directive form of humanistic psychotherapy developed by Carl Rogers that emphasizes unconditional positive regard and self-acceptance

systematic desensitization

form of exposure therapy used to treat phobias and anxiety disorders by exposing a person to the feared object or situation through a stimulus hierarchy

token economy

controlled setting where individuals are reinforced for desirable behaviors with tokens (e.g., poker chip) that be exchanged for items or privileges

transference

process in psychoanalysis in which the patient transfers all of the positive or negative emotions associated with the patient's other relationships to the psychoanalyst

unconditional positive regard

fundamental acceptance of a person regardless of what they say or do;
term associated with humanistic psychology

virtual reality exposure therapy

uses a simulation rather than the actual feared object or situation to
help people conquer their fears

14.3 Treatment Modalities

By the end of this section, you will be able to:

- Distinguish between the various modalities of treatment
- Discuss benefits of group therapy

Once a person seeks treatment, whether voluntarily or involuntarily, he has an **intake** done to assess his clinical needs. An intake is the therapist's first meeting with the client. The therapist gathers specific information to address the client's immediate needs, such as the presenting problem, the client's support system, and insurance status. The therapist informs the client about confidentiality, fees, and what to expect in treatment.

Confidentiality means the therapist cannot disclose confidential communications to any third party unless mandated or permitted by law to do so. During the intake, the therapist and client will work together to discuss treatment goals. Then a treatment plan will be formulated, usually with specific measurable objectives. Also, the therapist and client will discuss how treatment success will be measured and the estimated length of treatment. There are several different modalities of treatment: Individual therapy, family therapy, couples therapy, and group therapy are the most common.

INDIVIDUAL THERAPY

In **individual therapy**, also known as individual psychotherapy or individual counseling, the client and clinician meet one-on-one (usually from 45 minutes to 1 hour). These meetings typically occur weekly or every other week, and sessions are conducted in a confidential and caring environment. The clinician will work with clients to help them explore their feelings, work through life challenges, identify aspects of themselves and their lives that they wish to change, and set goals to help them work towards these changes. A client might see a clinician for only a few sessions, or the client may attend individual therapy sessions for a year or longer. The amount of time spent in therapy depends on the needs of the client as well as her personal goals.

GROUP THERAPY

In **group therapy**, a clinician meets together with several clients with similar problems. When children are placed in group therapy, it is particularly important to match clients for age and problems. One benefit of group therapy is that it can help decrease a client's shame and isolation about a problem while offering needed support, both from the therapist and other members of the group (American Psychological Association, 2014). A nine-year-old sexual abuse victim, for example, may feel very embarrassed and ashamed. If he is placed in a group with other sexually abused boys, he will realize that he is not alone. A child struggling with poor social skills would likely benefit from a group with a specific curriculum to foster special skills. A woman suffering from post-partum depression could feel less guilty and more supported by being in a group with similar women.

Group therapy also has some specific limitations. Members of the group may be afraid to speak in front of other people because sharing secrets and problems with complete strangers can be stressful and overwhelming. There may be personality clashes and arguments among group members. There could also be concerns about confidentiality: Someone from the group might share what another participant said to people outside of the group.

Another benefit of group therapy is that members can confront each other about their patterns. For those with some types of problems, such as sexual abusers, group therapy is the recommended treatment. Group treatment for this population is considered to have several benefits:

"Group treatment is more economical than individual, couples, or family therapy. Sexual abusers often feel more comfortable admitting and discussing their offenses in a treatment group where others are modeling openness. Clients often accept feedback about their behavior more willingly from other group members than from therapists. Finally, clients can practice social skills in group treatment settings. (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2009)"

Groups that have a strong educational component are called psycho-educational groups. For example, a group for children whose parents have cancer might discuss in depth what cancer is, types of treatment for cancer, and the side effects of treatments, such as hair loss. Often, group therapy sessions with children take place in school. They are led by a school

counselor, a school psychologist, or a school social worker. Groups might focus on test anxiety, social isolation, self-esteem, bullying, or school failure (Shechtman, 2002). Whether the group is held in school or in a clinician's office, group therapy has been found to be effective with children facing numerous kinds of challenges (Shechtman, 2002).

During a group session, the entire group could reflect on an individual's problem or difficulties, and others might disclose what they have done in that situation. When a clinician is facilitating a group, the focus is always on making sure that everyone benefits and participates in the group and that no one person is the focus of the entire session. Groups can be organized in various ways: some have an overarching theme or purpose, some are time-limited, some have open membership that allows people to come and go, and some are closed. Some groups are structured with planned activities and goals, while others are unstructured: There is no specific plan, and group members themselves decide how the group will spend its time and on what goals it will focus. This can become a complex and emotionally charged process, but it is also an opportunity for personal growth (Page & Berkow, 1994).

COUPLES THERAPY

Couples therapy involves two people in an intimate relationship who are having difficulties and are trying to resolve them. The couple may be dating, partnered, engaged, or married. The primary therapeutic orientation used in couples counseling is cognitive-behavioral therapy (Rathus & Sanderson, 1999). Couples meet with a therapist to discuss conflicts and/or aspects of their relationship that they want to change. The therapist helps them see how their individual backgrounds, beliefs, and actions are affecting their relationship. Often, a therapist tries to help the couple resolve these problems, as well as implement strategies that will lead to a healthier and happier relationship, such as how to listen, how to argue, and how to express feelings. However, sometimes, after working with a therapist, a couple will realize that they are too incompatible and will decide to separate. Some couples seek therapy to work out their problems, while others attend therapy to determine whether staying together is the best solution. Counseling couples in a high-conflict and volatile relationship can

be difficult. In fact, psychologists Peter Pearson and Ellyn Bader, who founded the Couples Institute in Palo Alto, California, have compared the experience of the clinician in couples' therapy to be like "piloting a helicopter in a hurricane" (Weil, 2012, para. 7).

FAMILY THERAPY

Family therapy is a special form of group therapy, consisting of one or more families. Although there are many theoretical orientations in family therapy, one of the most predominant is the systems approach. The family is viewed as an organized system, and each individual within the family is a contributing member who creates and maintains processes within the system that shape behavior (Minuchin, 1985). Each member of the family influences and is influenced by the others. The goal of this approach is to enhance the growth of each family member as well as that of the family as a whole.

Often, dysfunctional patterns of communication that develop between family members can lead to conflict. A family with this dynamic might wish to attend therapy together rather than individually. In many cases, one member of the family has problems that detrimentally affect everyone. For example, a mother's depression, teen daughter's eating disorder, or father's alcohol dependence could affect all members of the family. The therapist would work with all members of the family to help them cope with the issue, and to encourage resolution and growth in the case of the individual family member with the problem.

With family therapy, the nuclear family (i.e., parents and children) or the nuclear family plus whoever lives in the household (e.g., grandparent) come into treatment. Family therapists work with the whole family unit to heal the family. There are several different types of family therapy. In **structural family therapy**, the therapist examines and discusses the boundaries and structure of the family: who makes the rules, who sleeps in the bed with whom, how decisions are made, and what are the boundaries within the family. In some families, the parents do not work together to make rules, or one parent may undermine the other, leading the children to act out. The

therapist helps them resolve these issues and learn to communicate more effectively.

In **strategic family therapy**, the goal is to address specific problems within the family that can be dealt with in a relatively short amount of time. Typically, the therapist would guide what happens in the therapy session and design a detailed approach to resolving each member's problem (Madanes, 1991).

Summary

There are several modalities of treatment: individual therapy, group therapy, couples therapy, and family therapy are the most common. In an individual therapy session, a client works one-on-one with a trained therapist. In group therapy, usually 5–10 people meet with a trained group therapist to discuss a common issue (e.g., divorce, grief, eating disorders, substance abuse, or anger management). Couples therapy involves two people in an intimate relationship who are having difficulties and are trying to resolve them. The couple may be dating, partnered, engaged, or married. The therapist helps them resolve their problems as well as implement strategies that will lead to a healthier and happier relationship. Family therapy is a special form of group therapy. The therapy group is made up of one or more families. The goal of this approach is to enhance the growth of each individual family member and the family as a whole.

Review Questions

Exercise:

Problem:

A treatment modality in which 5–10 people with the same issue or concern meet together with a trained clinician is known as _____.

- A. family therapy
- B. couples therapy
- C. group therapy

D. self-help group

Solution:

C

Exercise:

Problem: What happens during an intake?

- A. The therapist gathers specific information to address the client's immediate needs such as the presenting problem, the client's support system, and insurance status. The therapist informs the client about confidentiality, fees, and what to expect in a therapy session.
- B. The therapist guides what happens in the therapy session and designs a detailed approach to resolving each member's presenting problem.
- C. The therapist meets with a couple to help them see how their individual backgrounds, beliefs, and actions are affecting their relationship.
- D. The therapist examines and discusses with the family the boundaries and structure of the family: For example, who makes the rules, who sleeps in the bed with whom, and how decisions are made.

Solution:

A

Critical Thinking Question

Exercise:

Problem: Compare and contrast individual and group therapies.

Solution:

In an individual therapy session, a client works one-on-one with a trained therapist. In group therapy, usually 5–10 people meet with a trained group therapist to discuss a common issue, such as divorce, grief, eating disorder, substance abuse, or anger management.

Glossary**confidentiality**

therapist cannot disclose confidential communications to any third party, unless mandated or permitted by law

couples therapy

two people in an intimate relationship, such as husband and wife, who are having difficulties and are trying to resolve them with therapy

family therapy

special form of group therapy consisting of one or more families

group therapy

treatment modality in which 5–10 people with the same issue or concern meet together with a trained clinician

individual therapy

treatment modality in which the client and clinician meet one-on-one

intake

therapist's first meeting with the client in which the therapist gathers specific information to address the client's immediate needs

strategic family therapy

therapist guides the therapy sessions and develops treatment plans for each family member for specific problems that can be addressed in a short amount of time

structural family therapy

therapist examines and discusses with the family the boundaries and structure of the family: who makes the rules, who sleeps in the bed with whom, how decisions are made, and what are the boundaries within the family

14.4 Substance-Related and Addictive Disorders: A Special Case

By the end of this section, you will be able to:

- Recognize the goal of substance-related and addictive disorders treatment
- Discuss what makes for effective treatment
- Describe how comorbid disorders are treated

Addiction is often viewed as a chronic disease. The choice to use a substance is initially voluntary; however, because chronic substance use can permanently alter the neural structure in the prefrontal cortex, an area of the brain associated with decision-making and judgment, a person becomes driven to use drugs and/or alcohol (Muñoz-Cuevas, Athilingam, Piscopo, & Wilbrecht, 2013). This helps explain why relapse rates tend to be high. About 40%–60% of individuals **relapse**, which means they return to abusing drugs and/or alcohol after a period of improvement (National Institute on Drug Abuse [NIDA], 2008).

The goal of substance-related treatment is to help an addicted person stop compulsive drug-seeking behaviors (NIDA, 2012). This means an addicted person will need long-term treatment, similar to a person battling a chronic physical disease such as hypertension or diabetes. Treatment usually includes behavioral therapy and/or medication, depending on the individual (NIDA, 2012). Specialized therapies have also been developed for specific types of substance-related disorders, including alcohol, cocaine, and opioids (McGovern & Carroll, 2003). Substance-related treatment is considered much more cost-effective than incarceration or not treating those with addictions (NIDA, 2012).

WHAT MAKES TREATMENT EFFECTIVE?

Specific factors make substance-related treatment much more effective. One factor is duration of treatment. Generally, the addict needs to be in treatment for at least three months to achieve a positive outcome (Simpson, 1981; Simpson, Joe, & Bracy, 1982; NIDA, 2012). This is due to the psychological, physiological, behavioral, and social aspects of abuse (Simpson, 1981; Simpson et al., 1982; NIDA, 2012). While in treatment, an

addict might receive behavior therapy, which can help motivate the addict to participate in the treatment program and teach strategies for dealing with cravings and how to prevent relapse. Also, treatment needs to be holistic and address multiple needs, not just the drug addiction. This means that treatment will address factors such as communication, stress management, relationship issues, parenting, vocational concerns, and legal concerns (McGovern & Carroll, 2003; NIDA, 2012).

While individual therapy is used in the treatment of substance-related disorders, group therapy is the most widespread treatment modality (Weiss, Jaffee, de Menil, & Cogley, 2004). The rationale behind using group therapy for addiction treatment is that addicts are much more likely to maintain sobriety in a group format. It has been suggested that this is due to the rewarding and therapeutic benefits of the group, such as support, affiliation, identification, and even confrontation (Center for Substance Abuse Treatment, 2005). For teenagers, the whole family often needs to participate in treatment to address issues such as family dynamics, communication, and relapse prevention. Family involvement in teen drug addiction is vital. Research suggests that greater parental involvement is correlated with a greater reduction in use by teen substance abusers. Also, mothers who participated in treatment displayed better mental health and greater warmth toward their children (Bertrand et al., 2013). However, neither individual nor group therapy has been found to be more effective (Weiss et al., 2004). Regardless of the type of treatment service, the primary focus is on abstinence or at the very least a significant reduction in use (McGovern & Carroll, 2003).

Treatment also usually involves medications to detox the addict safely after an overdose, to prevent seizures and agitation that often occur in detox, to prevent reuse of the drug, and to manage withdrawal symptoms. Getting off drugs often involves the use of drugs—some of which can be just as addictive. Detox can be difficult and dangerous.

COMORBID DISORDERS

Frequently, a person who is addicted to drugs and/or alcohol has an additional psychological disorder. Saying a person has **comorbid disorders**

means the individual has two or more diagnoses. This can often be a substance-related diagnosis and another psychiatric diagnosis, such as depression, bipolar disorder, or schizophrenia. These individuals fall into the category of mentally ill and chemically addicted (MICA)—their problems are often chronic and expensive to treat, with limited success. Compared with the overall population, substance abusers are twice as likely to have a mood or anxiety disorder. Drug abuse can cause symptoms of mood and anxiety disorders and the reverse is also true—people with debilitating symptoms of a psychiatric disorder may self-medicate and abuse substances.

In cases of comorbidity, the best treatment is thought to address both (or multiple) disorders simultaneously (NIDA, 2012). Behavior therapies are used to treat comorbid conditions, and in many cases, psychotropic medications are used along with psychotherapy. For example, evidence suggests that bupropion (trade names: Wellbutrin and Zyban), approved for treating depression and nicotine dependence, might also help reduce craving and use of the drug methamphetamine (NIDA, 2011). However, more research is needed to better understand how these medications work—particularly when combined in patients with comorbidities.

Summary

Addiction is often viewed as a chronic disease that rewires the brain. This helps explain why relapse rates tend to be high, around 40%–60% (McLellan, Lewis, & O'Brien, & Kleber, 2000). The goal of treatment is to help an addict stop compulsive drug-seeking behaviors. Treatment usually includes behavioral therapy, which can take place individually or in a group setting. Treatment may also include medication. Sometimes a person has comorbid disorders, which usually means that they have a substance-related disorder diagnosis and another psychiatric diagnosis, such as depression, bipolar disorder, or schizophrenia. The best treatment would address both problems simultaneously.

Review Questions

Exercise:

Problem:

What is the minimum amount of time addicts should receive treatment if they are to achieve a desired outcome?

- A. 3 months
- B. 6 months
- C. 9 months
- D. 12 months

Solution:

A

Exercise:

Problem:

When an individual has two or more diagnoses, which often includes a substance-related diagnosis and another psychiatric diagnosis, this is known as _____.

- A. bipolar disorder
- B. comorbid disorder
- C. codependency
- D. bi-morbid disorder

Solution:

B

Exercise:

Problem:

John was drug-free for almost six months. Then he started hanging out with his addict friends, and he has now started abusing drugs again. This is an example of _____.

- A. release
- B. reversion
- C. re-addiction
- D. relapse

Solution:

D

Critical Thinking Question

Exercise:

Problem:

You are conducting an intake assessment. Your client is a 45-year-old single, employed male with cocaine dependence. He failed a drug screen at work and is mandated to treatment by his employer if he wants to keep his job. Your client admits that he needs help. Why would you recommend group therapy for him?

Solution:

The rationale behind using group therapy for addiction treatment is that addicts are much more likely to maintain sobriety when treatment is in a group format. It has been suggested that it's due to the rewarding and therapeutic benefits of the group, such as support, affiliation, identification, and even confrontation. Because this client is single, he may not have family support, so support from the group may be even more important in his ability to recover and maintain his sobriety.

Glossary

comorbid disorder

individual who has two or more diagnoses, which often includes a substance abuse diagnosis and another psychiatric diagnosis, such as depression, bipolar disorder, or schizophrenia

relapse

repeated drug use and/or alcohol use after a period of improvement from substance abuse